Connecticut
Medicaid Managed Care Council

Legislative Office Building Room 3000, Hartford CT 06106
(860) 240-0321 Info Line (860) 240-8329 FAX (860) 240-8307
www.cga.state.ct.us/ph/medicaid

Meeting Summary: July 19, 2002

Present: Sen. Toni Harp (Chair), Rep. Vickie Nardello, David Parrella, Rose Ciarcia (DSS), David Guttchen (OPM), Thomas Deasey (Comptroller Office), Dr. Ardel Wilson (DPH), Dr. Wilfred Reguero, Dr. Edward Kamens, Janice Perkins, Patrick Carolan (MC plans), Ellen Andrews, Irene Jay Liu, Judith Solomon, Lisa Sementelli, Jeffrey Walter.
Also present: Charlene Cassamento, Martha Okafor (DSS), William Diamond (ACS), Jesse White Frese (FQHC), Chet Brodnicki (Child Guidance Clinics), Sylvia Kelly (CHNCT), Joan Morgan (FirstChoice/Preferred One), Dr. Elizabeth Malko for Deborah Hine (Anthem BCFP), April Davis (Anthem), Dr. Beth Smith (CHNCT), Mary Alice Lee (CHC), Mariette McCourt (Council staff).

Department of Social Services
Contract & Capitation rates FY03
David Parrella reviewed the HUSKY contract status:

- MCO contracts have been extended to the end of September 2002. Two plans have signed the 3-month extension; two are signing a contract extension month-by-month.
- A new HUSKY contract will be issued in October 2002, reflecting:
    - Federal regulatory changes for the HUSKY B, Title XXI program; these will not result in major program changes.
    - State Plan amendment changes, contingent upon legislative approval of the implementing language based on the FY03 budget that eliminates **Medicaid optional services including psychology, chiropractic, naturopath and podiatry services, physical therapy, occupational and speech therapy and non-emergency medical transportation. These service reductions will not affect services to children, but will impact HUSKY A adults and those in fee-for-service (FFS). The transportation exceptions under the adult SAGA that includes transportation for dialysis, radiation and chemotherapy will remain.** These changes must be included in the implementer bill language, then published in the Law Journal and state newspapers, followed by DSS State Plan changes and FFS system changes prior to inclusion in the October 2002 HUSKY MCO contracts. Manage Care organizations' capitation rates will be adjusted accordingly, based on the approval of service reductions in the implementer session. Providers and clients will receive 30 days notice prior to the effective date of the changes upon approval of the changes.
- The July 2003 HUSKY contract will include:
    - Title XIX (HUSKY A) revised federal regulations, finalized by the Centers for Medicare & Medicaid (CMS) August 13, 2002: states have one year to come into compliance with these revised regulations.

- HUSKY program changes that include a dental service and behavioral health carve-out. With the removal of these services, the HUSKY MCO contract will essentially become a basic medical model.

HUSKY MCO rates, which will be based on the FY03 budget negotiated by the General Assembly (GA) leadership and the Governor's office during the 2002 special session, and placed in the statutory implementer language, have not been finalized. Mr. Parrella stated that an analysis of the Upper Payment Limit (UPL) has been made, including cost of living increases and conversion of dollars into the rates, offsetting the repeal of the commercial MCO tax credit for Medicaid participation. Changes in the Medicaid service package as part of the negotiated budget will be included in the HUSKY rate analysis, upon GA passage of the 2002 implementer bill. The Department will be able to present more information in the September Council meeting.

The RFP for the Administrative Service Organization (ASO) that will manage the behavioral health benefits for HUSKY A & B, Medicaid fee-for-service and the state assistance (SAGA) populations should be finalized in September 2002. Charlene Cassamento and Dr. Mark Schaefer (DSS) have worked diligently to develop this RFP with the 3 agencies (DSS<DCF & DMHAS). Martha Okafor (DSS) has been working with the Office of Health Care Access (OHCA) in the development of the dental ASO RFP, which will include a linkage for purchasing dental services with the State Employee Health Plan.

Council questions/comment highlights include:

- DSS will provide the Council with a list of the federal changes for HUSKY A after their meeting with CMS July 25, 2002.
- MCO capitation rate configuration process:
  - DSS has an actuarial basis for the capitation rates minus the service carve-outs for July 03. Rates based on this analysis will be in the RFP released this Fall. The HUSKY rate setting now involves a triangulation approach, per the federal regulations that allow states to use the FFS rates as a reference but now requires more focus on incurred cost. The Department will use the MCO audited financial reports, utilization rates provided by the encounter data and trending forward of the FFS rates.
  - The Department believes it has a basis for establishing the dental and BH ASO administrative costs from the current MCO/subcontractor administrative costs.
  - The Department must abide by State rules in disclosing the specifics of the dental or BH RFP; however they will share as much s they can, within the law, about the procurement process. There will public Bidders Conferences that the Council members may attend. I**nterested parties should write a letter to Kathleen Brennan, Department of Social Services, 9th floor, 25 Sigourney Street, Hartford, CT 06106, indicating interest area (HUSKY dental and/or BH) for the Bidders list. The Bidders Conference date and RFP will be sent to those on the list.**
  - When questioned if there will be rate increases in the carve-out, as the intent is to get more children into services, DSS stated that the intention of the new dental design is to provide more children with dental access without forecasting increased dental reimbursement rates.
- Ancillary services and identification of responsibility has been considered in the rate

configuration that will include the carve-outs. For example, in dental, transportation could be the responsibility of the ASO vendor, the HUSKY MCO or DSS: the Department is leaning toward leaving this in the MCO costs. A key Behavioral Health issue is pharmacy costs: DSS plans to keep this in the HUSKY MCO rates. Mr. Parrella noted that in the current system service costs and contractual responsibility are within one entity, the MCO. Service carve outs complicate the processes of accountability and maintaining the necessary linkages for ancillary services between the carve-out entity and the MCO.

- Sen. Harp stated that the legislators voted on a budget that was negotiated by the GA leadership and the Governor, but did not vote on the operationalization of the budget line items. The Senator did not know until this meeting that provider services and payments, such as psychologists were limited. If this is the case, who will provide services in the BH carve-out? Are there plans to limit other provider types? The Department commented that the agency is taking its direction from the Administration related to the content of the budget. The 30% growth in HUSKY (approximately 70,000) over the last year with a 10% budgeted increase creates a financial crisis in the Medicaid program. Maintaining funding for current service options for an increasing volume of clients without budgetary resources is very difficult to achieve.
- Families and providers continue to struggle with the current program design, which places responsibility for subcontractor services with a single entity (MCO). Budget reductions in member outreach raises concerns about resource availability for the upcoming program changes that place accountability for some services in the ASO(s) and other services remain in the managed care program.

HUSKY MCO Quarterly Claims Report

Charlene Cassamento (DSS) reviewed the 1Q02 quarterly HUSKY A & B claims report required by statute and MCO contractual provisions. The plans submit data on claims inventory (dollars & volume), claims processing turn around times and claims paid in excess of 45 days. The claims data represents "clean" claims; the required report content did not include number of denied claims. Ms. Cassamento noted that the 2nd quarterly report (April-June), due in September, would be incomplete as MCO payments from the State were delayed in June, and paid in July. The report summary follows:

	Anthem BCFP	**CHNCT**	**FirstChoice/P-1**	**Health Net**
% claims paid within 45 days	97.8%	86%	89.6%	98.7%
Pharmacy	100%	100%	100%	100%
Dental	100%	100%	100%	100%
Vision	100%	100%	100%	100%
Mental Health		100%	99.5%	93.8%

Fig. 1 Claims Inventory 1Q02 VS 4Q01 1-30 Days

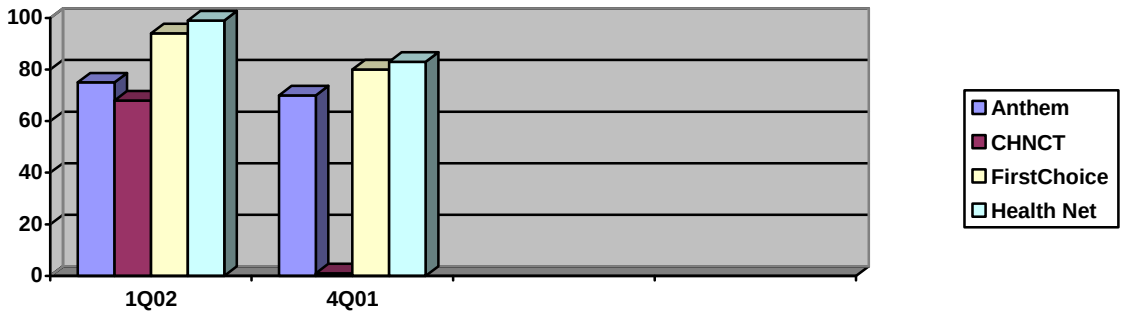
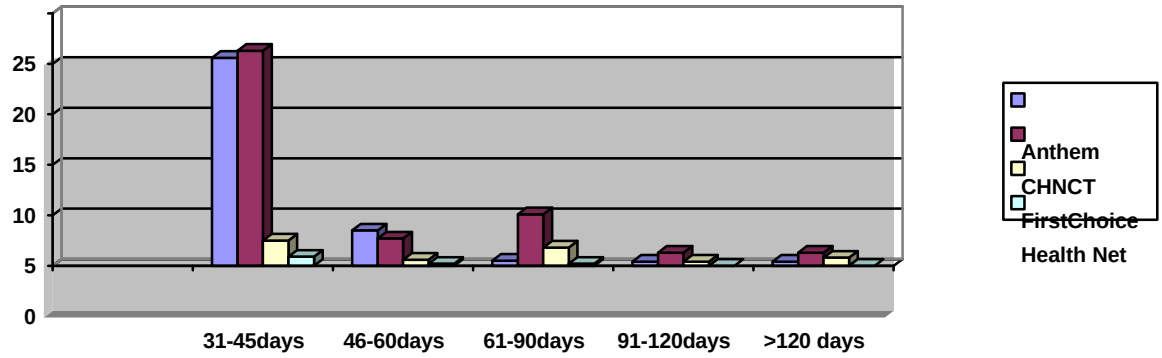


Fig.2 Total Volume of Unprocessed & Unpaid Adjudicated Claims (see fig 1 for 1-30 day claims inventory)



Observations:

- CHNCT was undergoing a claims system conversion during the 4Q01, therefore there was delayed claims processing in that quarter. Increased enrollment did not deter an improvement in the movement of claims in 1Q02, with 68% in the 30-day batch compared to 1% in the 4Q01 (Fig 1).
- All plans showed a higher number of adjudicated claims in the inventory at the 1-30 day batch.
- Anthem and CHNCT had the higher number of claims in the 31-45 days batch.
- Health Net reported on claims paid within 45 days for skilled nursing visits: 72% were paid within 45 days in 4Q01, and 49% in 1Q02. Health Net worked with their home care subcontractor, setting a goal of 0 claims unpaid beyond 45 days. In April 2002 373 claims were paid >45 days. In July 2002 the number of unpaid claims beyond 45 days has decreased to 88.

Council members representing BH services expressed concern that the Health Net 94% BH claims payment within 45 days is inconsistent with provider experience. The reports account for 'clean' claims, not all claims. It was recommended that future reports include the volume of all claims versus 'clean' claims. Ms Cassamento noted that the implementation of HIPAA common codes would provide this broader view of claims; providers believe this information is needed now. The Department is working with MCO's and providers on outstanding claims (AR) and will have more information in September on the resolution of this issue.

Senator Harp stated that the current collection tool, in looking at 'clean' claims only, misses the unpaid AR patterns that have almost crippled the behavioral health system. Sen. Harp stated that it is unconscionable not to have a process to assess patterns of AR's before the system changes again. The Senator thanked the MCO's and providers' work in addressing this problem.

Utilization reporting Format

Hilary Silver reported on the revised schedule for HUSKY A utilization reports that will now be provided on a semiannual time period rather the previous quarterly basis. The reporting format was changed in order to identify more meaningful utilization changes over a longer time period. According to DSS, quarterly fluctuations in utilization may not reflect access trends. Report Schedule:

Reports	Due Date
EPSDT, including dental utilization	10/1 (due 10/14 in 02) & 4/1
Other, including prescriptions, dental exams & services and vision exams	10/1 (10/14/02) & 4/1
Inpatient, ED visits, MH & SA treatment	1/1 & 7/1
Prenatal/maternal care including % receiving complete PNC, LBW & VLBW babies and postpartum care	1/1 & 7/1

Two new reports will be added:

- Managed care case management (CM) data has been submitted by the MCO's since the 4Q00. The Council requested a report on this important information; however the lack of plan uniformity of data submission reportedly made the assessment of the data difficult. The Department worked with the MCO's, with Council input, to refine the report indicators. It was suggested that a primary and secondary diagnosis be included, as more complex cases may warrant CM; DSS will consider this. Janice Perkins (Health Net) commented that this report is not as clearcut as the other utilization reports. There will be variations among MCOs on the criteria for implementing CM, which may be applied at different levels, depending on the acuity and complexity of the client's need. All MCO case management services will be reported beginning October 2002.

  The report indicators include: member ID, DOB, CM referral source & reason for referrals, type of case/diagnosis, onset of CM services, CM ID, attainment of desired outcome/goal of CM, client CM status (open or closed) & reason for closure.
- Pursuant to PA No 02-3 that requires MCO/dental & BH subcontractor quarterly reporting of revenues and medical and administrative expenses, the Department has developed the reporting format to be used by the MCOs, with the first report due November 2002.

Children's Health Council Reports

Other HUSKY services for children without documented ambulatory care 2001

Subsequent to the CHC presentation of the 2001 ambulatory care (AC) utilization report of continuously enrolled children aged 2-19 years that showed that 17.6% of these children had no encounter data for ambulatory care, Senator Harp requested the CHC determine if this cohort had

received any other HUSKY services. Mary Alice Lee reported on the findings obtained from the encounter database:

	1999-200	2000-2001
% With no Ambulatory Care	**19% (22,496 children)**	**18% (21,252)**
% With no recorded services	**8% (9,653)**	**8% (9,299)**
Other HUSKY services received by these children	*25%(inpatient, vision, BH) *27% had prescriptions *32% had @ least 1 dental visit	*32% other medical care *23% prescriptions *29% dental care
Race/Ethnicity/no care(AC & other)	*11% African American *6.3% White *7% Hispanic	*11% African American *6.2% white *6.6% Hispanic
HUSKY MCO/no care (AC & other)	*Anthem 8.7% *CHNCT 8.4% *Health Net 7.1% *P-1 11.2% *Plan changers 7.5%	*Anthem 8.1% *CHNCT 7.7% *Health Net 6.9% *P-1 13.4% *Plan changers 4.6%

Ms. Lee postulated possible reasons for the absence of ambulatory care in the encounter data that included incomplete encounter data, no data submitted for adolescents secondary to confidentiality concerns, care in MCO out-of-network sites, well visits for children aged 6-10 years is required every two years, family has other primary health insurance coverage or moved out of state. The largest number of HUSKY members without documented ambulatory care and any other HUSKY services during this time period were adolescents aged 16-19 years and African American children.

Asthma in HUSKY A

The CHC has monitored asthma prevalence for the past four years for HUSKY A children < 21 years of age using the inpatient and outpatient asthma ICD-9 diagnoses. The full report can be obtained from the CHC website www.childrenshealthcouncil.org.:

- The estimated prevalence of pediatric asthma FY98-01 remains fairly stable at 8.8-9.8%. Children aged > 1 year had a higher prevalence of asthma, on average, over the past three years.
- Hispanic children have a higher asthma prevalence and children in Bridgeport showed a higher prevalence in FY99-01 as compared to Hartford, New Haven and other towns.
- ED visits for asthma were increased in FY01 (28%) while there was a decrease in the frequency of more than one office visit (48% of children with asthma diagnosis). ED care was higher for males, AA & Hispanic children compared to White children and those children living in New Haven compared to those in less urban areas. Asthmatic children in Anthem had lower ED visit rates.
- While hospitalization rates associated with asthma remained stable (5%), higher hospitalization rates were found in children <6 years, AA children and those living in New Haven. Anthem members had lower rates compared to the other three plans.
- 20% had a primary care visit within 2 weeks of an ED visit for an asthma diagnosis; 24% within 4 weeks of the ED visit (HEDIS measure).
- 41% had office/clinic visits within 2 weeks of hospitalization and 44% had an outpatient visit 4

weeks after hospitalization.

The report concludes that one in ten HUSKY A children have received asthma related care. The data suggests that families with acute asthma care needs may be increasingly using the ED rather than their primary care setting and that the majority of children with asthma-related ED visits or hospitalizations did not have a record of timely follow up primary care visits.

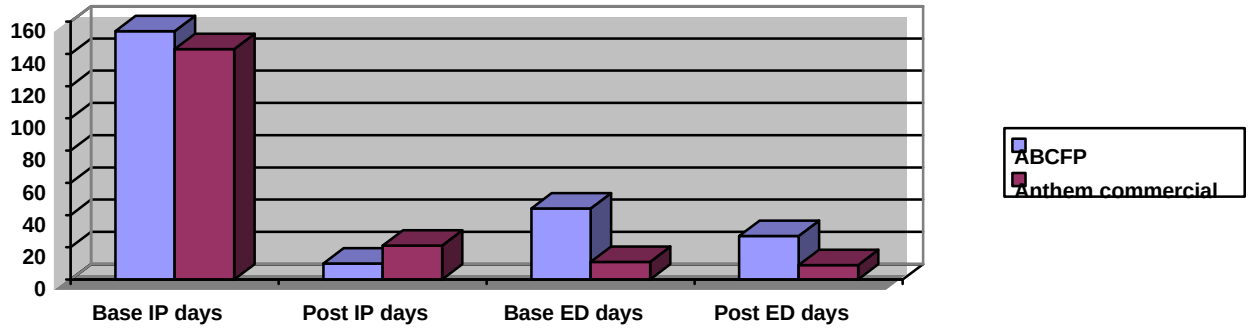
Council discussion highlights and recommendations:

- Asthma preventive programs need to be based on the changing incidence of asthma rather than prevalence. While the individual FY encounter data cannot identify newly diagnosed asthma cases, using the Medicaid ID may allow tracking of new asthma occurrences over the four-year monitoring period.
- Higher prevalence in certain geographic areas (MCO rates are adjusted for this) suggests the importance of identifying new cases and risk factor differences by area. The Department of Public Health has been mandated to develop an asthma surveillance process and is working with a task force focused on asthma in school-aged children. Both Bridgeport and New Haven are part of the National Asthma project that targets improved diagnosis and asthma severity assessment, therefore the prevalence numbers in those areas may be higher from improved clinical practice.
- Senator Harp recommended DSS consider the data on follow up asthma care with the MCO's and develop intervention strategies to incrementally improve the percentage of children receiving follow up primary care visits after either ED or hospitalization for asthma.
- It is most important to identify families with "no care" either for ambulatory visits or asthma follow up and identify the reason for this from the family's unique perspective, rather than rely on hypotheses for lack of access to health services.

Health Plans' Asthma Disease Management Programs

Anthem Blue Care Family Plan: April Davis, RN, MSN, Manager Medical Management

Ms. Davis described the Anthem *Winter Blitz* asthma quality care management program that targeted commercial members (24) and Husky members (32) with asthma related inpatient stays, ED visits and/or medication noncompliance documented during case management. The quality care management approach included August home visits for school aged children, a partnership with school nurses to ensure signed medication administration form, coordinated teaching & implementation of the primary practitioner care plan. The case management specific to the program included an asthma assessment, use of pharmacy data to monitor medication compliance, use of a one page bilingual Asthma Plan, consistent follow up with the MD and telephonic member follow up with evening calls and enhanced script, and joint QCM/Medical director presentations to targeted providers. Evaluation of the program included comparison of inpatient stays, ED use and/or medication compliance pre-program (9/1/00-3/31/01 with intervention period 9/1/01-3/31/02. The following summarizes the results: (ABCFP = HUSKY members , N=32; Anthem commercial N=24):



- There was a 94% reduction (144 days) of asthma inpatient (IP) days for the ABCFP members and a 39% reduction (27 days) of asthma ED days.
- For the commercial members, there was an 85% reduction (122 days) of inpatient days, and an 18% reduction (2 days) of ED days; the total baseline ED days (11) were lower that the ABCFP baseline ED days (44).
- **There was an overall 90% reduction in inpatient days for both groups.**
- Anthem's next steps include closely monitoring of members at highest risk, expand the follow up program, increase the focus on the Hartford area, risk stratify all BCFP members with 2 or more asthma claims and tailor interventions based on the risk stratification, develop full integration of asthma disease management and case management program.

<u>Community Health Network of CT: Elizabeth Smith MD, Medical Director</u>
Dr. Smith described the components of CHNCT's Asthma Disease Management program:

- Multi-pronged Asthma program that includes:
  - Asthma outreach: member education through an initial mailing of materials and the asthma action plan and three times a year follow up mailings with seasonally appropriate materials, including reminders for influenza vaccine.
  - Provider information through distribution of asthma treatment guidelines and action plan use, quarterly member-specific reports to encourage appropriate use of anti-inflammatory medications.
  - Asthma case management by R.N.'s for care coordination of high risk members, working with members and healthcare providers.
  - Asthma home care that involves intensive asthma education, environmental assessment, to members post hospital discharge or through healthcare provider referral.

Outcomes measures include ED utilization, hospitalizations and appropriate anti-inflammatory medication use.

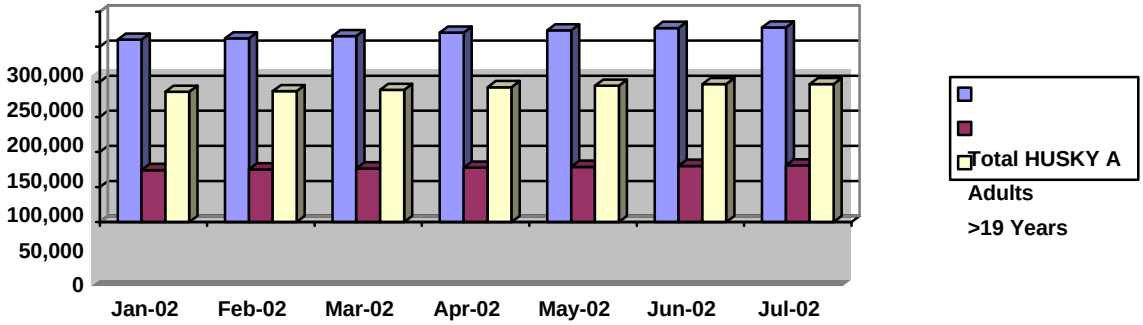
- Asthma ED collaborative study with DPH and CHNCT study that involved telephone survey of 200 members with an asthma-related ED visit. Findings:
  - 91% report use of same clinic/office (medical home).
  - 94% reported no problem with obtaining prescribed asthma medications.
  - 37.8% have a written asthma plan, used by 90.8% of those with a plan.
  - 43.8% report 1 or more persons in the home smoke; of these, 45% smoke inside.

- UCAN Control Asthma Program: funded with an AHRQ grant for 3 years, uses a "chronic care' model with the goal of understanding asthma severity and control issues, and measures impact of the provider and member intervention and outcomes. The program, begun in 2000, involves 4 Community Health Centers in New Haven, Bridgeport and Waterbury. The total number of member enrollment is 340, aged 5-18 years. Baseline information showed that:
    - Providers rated over 50% as having mild intermittent asthma, 19% with moderate persistent and 1% as severe persistent asthma.
    - Baseline asthma control ratings showed that moderate and severe asthmatics had less control over symptoms, prior to intervention that will be delivered over a 3-year period.

Senator Harp thanked the two health plans for their report and look forward to future reports on the effectiveness of the programs. FirstChoice and Health Net will report on their DM programs in September.

HUSKY Enrollment

William Diamond, Director of the HUSKY enrollment broker ACS (formerly Benova), reported on the July HUSKY A enrollment:



Net HUSKY B enrollment increased from 13,086 in June to 13,145 as of July 1. Mr. Diamond stated that there will be an increase in application and enrollment volume in September and October as a result of back-to-school initiatives.

In past years the enrollment numbers in July decreased in relation to children 's continuous eligibility renewal period. Subsequent to July 2000, the Department has sent earlier re-enrollment notices to families and is addressing retention barriers with funding from a Robert Wood Johnson grant. Senator Harp commended DSS and ACS for their efforts to maintain access to health coverage in the very good, nationally recognized HUSKY program.

The Medicaid Council will convene in September: there will be no meeting in August.